MAP-813
(Rev. 1/15/03)

BREAST & CERVICAL CANCER TREATMENT PROGRAM APPLICATION

DATE _____/_____/_____

COUNTY _____ PROGRAM CODE __**V**__ SSN _____ - ____ - _____

COPY OF SSN ATTACHED RESIDENT OF KENTUCKY? Y [ ] N [ ]

NAME _____
(First) (Middle I.) (Last)

HOME ADDRESS _____

CITY _____ STATE _____ ZIP_____

MAILING ADDRESS_____ _____
(ENTER IF DIFFERENT THAN HOME ADDRESS)

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ - _____ WORK PHONE (____) _____ - _____

BIRTH DATE _____ AGE _____ SEX _____ RACE: _____
(Month/Date/Year)

ARE YOU CURRENTLY COVERED BY OTHER MEDICAL INSURANCE? Y [ ] N [ ]
***IF "YES", PROVIDE COPY OF INSURANCE CARD OR COVERAGE

IS APPLICANT A U.S. CITIZEN OR QUALIFIED ALIEN? Y [ ] N [ ]
IF QUALIFIED ALIEN, ENTER THE APPROPRIATE IMMIGRATION AND NATURALIZATION SERVICE (INS) NUMBER _____

WAS APPLICANT SCREENED BY THE KWCSP IN THE PRIOR 3 MONTHS AND HAVE UNPAID MEDICAL BILLS IN THOSE SAME 3 MONTHS? Y [ ] N [ ]
MONTHS: _____ _____ _____

I certify all that entries are correct and true to the best of my knowledge and belief. I understand that this information will be used to determine eligibility for benefits from the Department for Medicaid Services. I understand that if I give false information or withhold information in order to receive assistance, I may be subject to prosecution for fraud. I understand that I have the right to request a Fair Hearing before an impartial hearing officer if I am dissatisfied with any Agency action. I understand that Social Security numbers will be used for various state and federal matches thorough the Income and Eligibility Verification System (IEVS) under the authority of IEVS benefits. This information will be disclosed to other agencies only as permitted by law. I understand that in accepting Medicaid, I assign my rights to third party payments from any source, including hospital or health insurance policies, and am willing to cooperate with the Department for Medicaid Services. I further understand that if I refuse to assign my rights to third party payments to the Department for Medicaid Services, I will be ineligible to receive a medical card. I understand that when I obtain medical services with a Medicaid card issued to the case member, I am responsible for notifying the medical provider of any hospital or health insurance policy

covering me. I agree to reimburse the Medicaid Program for services received which are later covered by insurance settlements or payments. I further give my consent to the Department for Medicaid services to make any necessary contacts to verify my statements or gain additional pertinent information.
The following are prohibited acts under federal and state law. Persons found guilty of these acts can be fined, imprisoned, and/or disqualified from receiving future medical assistance benefits for up to one year for the first offense:

- Lending your Medical Card to another person,
- Providing false information in order to gain or retain medical benefits,
- Concealing information in order to gain or retain medical benefits, including the existence of other medical insurance,
- Failing to report changes in order to gain or retain medical benefits,
- Applying for medical benefits for another person and using the card for yourself or someone else who is not eligible,
- Aiding someone else to do any of the above to gain medical benefits for a person who is not eligible.

SIGNATURE _____ DATE _____/_____/_____

WITNESS, IF SIGNED WITH A MARK _____

AGNECY USE ONLY

APPLICANT HAS BEEN SCREENED BY THE KENTUCKY WOMEN'S CANCER SCREENING PROGRAM AND IS IN NEED OF TREATMENT FOR BREAST AND/OR CERVICAL CANCER, INCLUDING A PRE-CANCEROUS CONDITION OR EARLY STAGE CANCER OF THE BREAST AND/OR CERVIX.

APPLICIANT NEEDS TREATMENT FOR:

- ☐ Breast Cancer (4 months)
- ☐ Cervical Cancer (3 months)
- ☐ Precancerous Cervical or Breast Disorder (2 months)

PHYSCIAN'S ESTIMATED DATE FOR TREATMENT TO BE COMPLETED _____

NURSE CASE MANAGER _____
(Signature)

LOCAL HEALTH DEPARTMENT ADDRESS _____

_____

HEALTH DEPARTMENT COUNTY _____

LOCAL HEALTH PHONE # (_____) _____ - _____ FAX # (_____) _____ - _____
